MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-Md

00948

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P. B. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)
Street No.: 9. Bay street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Russell Bayginger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Edith Richardson Bayginger Dead 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 26-1856

8. AGE: Years: 88 Months: 9 Days: 6 If less than one day: hrs. min.

9. Birthplace: Wayne Co. Ohio (Town, county, and state)
10. Usual occupation: retired
11. Industry or business: Farmer

FATHER
12. Name: James Bayginger
13. Birthplace: Doylestown Ohio

MOTHER
14. Maiden name: Mary Catherine Johnson
15. Birthplace: Wayne Co. Ohio.

16. Informant: Mr. Russell V. Bayginger
Address: 1219. E. church st. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan. 5. 1945 (month) (day) (year)
Cemetery or crematory: Hinckley Ohio
Location: Near Medina Ohio.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland

19. 1/2, 1945 (Date rec'd by registrar) Edward E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2nd 1945 at 12 40 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chronic myocarditis	10 yrs.
Due to: Generalized Arteriosclerosis	20 yrs
Senile Dementia	10 yrs
Due to: Accident causing fracture of right hip	6 wks.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Reduction of fracture & implanting plates & screws. Date of op.: Dec 5, 1944
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 11/18/44
Where did injury occur? Berlin (City or town) Wor. (County) Md (State)
Injured at home, farm, industry, public place (where?): Pitts St. Berlin Md
Means of injury: Fell on sidewalk Injured at work? No

23. SIGNATURE: F. S. Purcell, M. D. (Reported by Medical Examiner) M. D. or other
Address: Berlin, Md Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06949

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: 306 Naylor st.
How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 Naylor st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Eliza Betts

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widow

6.(b) Name of husband or wife William Betts
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) July 13-1876

8. AGE: Years 68 Months 5 Days 25 If less than one day ..... hrs. ..... min.

9. Birthplace R.D. Bunters Delaware (Town, county, and state)
10. Usual occupation Home wife at Home
11. Industry or business
FATHER 12. Name William P. Records
13. Birthplace Sussex C. Delaware
MOTHER 14. Maiden name Elizabeth Whaltow
15. Birthplace Sussex C. Delaware
16. Informant Mr. Arthur D. Betts
Address 306 Naylor st. Salisbury Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof Jan. 11-1945 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Maryland
18. Funeral Director Mallory & Walter R. Mallory
Address Salisbury Maryland.
19. 1/11 1945 Harriet J. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 45 at 3.15 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 8, 45 to Jan 8 45
and that I last saw h alive on Jan 8, 1945
Immediate cause of death Acute Dilatation — DURATION 2 hr
Due to Heart
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury Injured at work?

23. SIGNATURE D. Allen Dealer M. D. or other
Address Salisbury Md. Date signed 1/9/45

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

00950

Reg. Dist. No. 3-33

1. PLACE OF DEATH: Wicomico

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, Institution or street address where death occurred: P. H. Dept

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #1.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Gratelle Marie Bradford (Baby Girl Bradford)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2nd 1944

8. AGE: Years	Months	Days	If less than one day
	1	23	hrs. min.

9. Birthplace: R.D. #1 Parsonsburg Md

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: John Walter Bradford

13. Birthplace: Pittsville Md.

MOTHER — 14. Maiden name: Gertrude Wootten

15. Birthplace: Pittsville Md

16. Informant: Mrs. J. Walter Bradford

Address: R.D. #1. Parsonsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 28-45 (month) (day) (year)

Cemetery or crematory: Pittsville Cem.

Location: Pittsville Maryland

18. Funeral director: Holloway & Walter P. Holloway

Address: Salisbury Maryland.

19. Jan 25 1945 (Date rec'd by registrar) Russell D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25th 1945 at 10 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 24 1945 to Jan. 25 1945 and that I last saw her alive on Jan. 25 1945

Immediate cause of death	DURATION
Prematurity	Birth
Due to:	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. Rivers Hanson M.D.

M. D. or other

Address: Salisbury Md. Date signed: 1/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

06951

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Allen, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Allen, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Joseph L. Brewington

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Married

6.(b) Name of husband or wife: Ella Brewington

6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): Oct 18 about 1865

8. AGE: Years	Months	Days	If less than one day
about 79	—	—	..... hrs. ..... min.

9. Birthplace: Allen, Md (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Farming

FATHER — 12. Name: George Brewington

FATHER — 13. Birthplace: Allen, Md

MOTHER — 14. Maiden name: Martha Pillatt

MOTHER — 15. Birthplace: Allen, Md

16. Informant: Mrs. Ella Brewington

Address: Allen, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 15 1945 (month) (day) (year)

Cemetery or crematory: Tyndall's

Location: Allen, Md

18. Funeral director: James A. Stewart

Address: Salisbury, Md

19. 1/16 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1944, to Jan 1945 and that I last saw h... alive on Jan 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wks
Due to: Hypertension	2 yrs
Due to: Arteriosclerosis	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. D. Lang M.D. M. D. or other

Address: Princess Anne Md Date signed 1/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Lewis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06952

Reg. Dist. No. 332

1. PLACE OF DEATH: Wicomico

County ..... Wicomico

City or town ..... Willards

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, institution, or street address where death occurred: Main street

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Willards

(If outside city or town limits, write RURAL and give nearest town)

Street No. Main street

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME James Franklin Brittingham

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna C. Brittingham

6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) March 1 - 1868

8. AGE:

Years	Months	Days	If less than one day
76	10	29	..... hrs. ..... min.

9. Birthplace R.F.D. Pittsville Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business .....

FATHER

12. Name John Henry Brittingham

13. Birthplace R.F.D. Pittsville Md

MOTHER

14. Maiden name Eliza Jane Brittingham

15. Birthplace R.F.D. Pittsville Md.

16. Informant Mrs. Anna C. Brittingham

Address Willards Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 4-45 (month) (day) (year)

Cemetery or crematory Dennis Cem.

Location Near Willards Md

18. Funeral director Hillman & C. Walter R. Hillman

Address Salisbury Maryland.

19. Feb 1 (Date rec'd by registrar) 19 45 Lillian R. Davis Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 19 45 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 44, to Day of death 19 ..... and that I last saw h.. alive on Day of death 19 .....

Immediate cause of death Adenocarcinoma Left Kidney — DURATION 6 mos.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

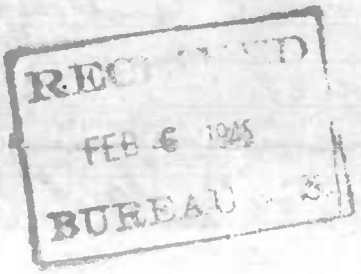
23. SIGNATURE Frank A. Lewis M.D. M. D. or other

Address Willards Md Date signed 2-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
FEB 6 1945
BUREAU

STATE OF MARYLAND—CERTIFICATE OF DEATH

00953

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County Wicomico Registration Dist. No. 332

Village or City Pittsville Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Sewell Tarpin Dennis If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Sara Elizabeth Dennis

6. DATE OF BIRTH (month, dey, and year) April 5 1863

7. AGE Yeers	Months	Oeys	If LESS than 1 day, hrs. or min.
82	9	15	

OCCUPATION

8. Trede, profession, or perticular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work wes done, es SILK MILL, SAW MILL, BANK, etc.

10. Dete deceesed last worked at this occupetion (month and yeer) 1931 — 11. Total time (yeers) spent in this occupation

12. BIRTHPLACE (city or town) (Stete or country) Maryland

FATHER

13. NAME Levin Dennis

14. BIRTHPLACE (city or town) (Stete or country) Md

MOTHER

15. MAIDEN NAME Harriett Dennis

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Mrs. L. E. Dennis (Address) Pittsville Md

18. BURIAL, CREMATION, OR REMOVAL Piece Parkers Cemetary Oete Jan 23, 1945

19. UNDERTAKER Wm Howard Wells (Address) Pittsville Md

20. FILED 3-19, 1945 Lillian R. Davis Registrar. Local

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 20 (Day), 1945 (Yeer)

22. I HEREBY CERTIFY, That I attended deceased from August, 1944, to day of death, 1945. I last saw him alive on 1-28-45, 19, death is said to have occurred on the date stated above, at 7-15 P m.

The PRINCIPAL CAUSE OF DEATH end related ceuses of importence were es follows:

	Data of onset
Cerebral hemorrhage 1st one	Aug 1944.
(\ " 2nd one	1-19-45

Other Contributary Causes of importance: hypertension. Arteriosclerosis.

Name of operation Date of

What test confirmed diegnosis? Clinical Was there an eutopsy? No

23. If deeth was due to externel ceuses (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Wes diseese or injury in eny way releted to occupation of deceased? No

If so, specify

(Signed) Frank R. Leinz M. D.

(Address) Willards Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic" but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

(Dr. Daisy)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

06954

CERTIFICATE OF DEATH

Reg. Dist. No. 323

1. PLACE OF DEATH
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: P. H. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cooper St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joyce Ruth Dennis

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Nov. 22 - 1941

8. AGE: Years 3 | Months 2 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace P. H. Hoyt Salisbury Md. (town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Winfield Dennis
13. Birthplace R.D. #3 Salisbury Md.
MOTHER 14. Maiden name Ruth Smith
15. Birthplace Siloam Md.
16. Informant Mr. Winfield Dennis
Address Cooper St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date filed Jan. 1 - 1945 (month) (day) (year)
Cemetery or crematory Parsonsburg Church Cem.
Location Parsonsburg Md.
18. Funeral director Holloway & Walter R. Holloway
Address Salisbury Md.
19. 2/1/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29th 1945 at 10.30 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26 1945, to Jan 29 1945
and that I last saw h.. alive on Jan 29 1945

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to Coryza	6 days
Due to	
Other conditions Intestinal Auto Intoxication	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. O. Daisy M.D.
M. D. or other
Address Jewland Date signed 1/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Wicomico Co.
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Houston St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Juanita E Ellis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 16. 1944

8. AGE: Years | Months: 2 | Days: four | If less than one day: hrs. min.

9. Birthplace: Salisbury Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Proner Ellis
13. Birthplace: Salisbury Md

MOTHER
14. Maiden name: Mary [illegible] Irby
15. Birthplace: Winston Salem N.C

18. Informant: Mary Irby
Address: Houston St.

17. Burial (Burial, cremation, or removal (Which?)) Date thereof: Jan 5 1945 (month) (day) (year)
Cemetery or crematory: Parsons Cem
Location: Salisbury Md

18. Funeral director: F. B. Pitts
Address: Salisbury Md

19. 1/6/45 (Date rec'd by registrar) Harriet L Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3rd 1945, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19— to Jan 3 19—
and that I last saw him alive on Jan 3 19—

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] Deputy Md Examiner M. D. or other
Address: Salisbury Md Date signed: 1/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1272)

00956

CERTIFICATE OF DEATH

Reg. Dist. No. 3[illegible]3

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury R.4. D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One week

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? one week

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury R.4. D. (If outside city or town limits, write RURAL and give nearest town)

Street No. No (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Maggie Gadlee

3.(b) Social Security Number: Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.g.	Married

6.(b) Name of husband or wife: James Gadlee

6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): about 1908

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
about 36	—	—		

9. Birthplace: Snowhill (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER — 12. Name: Chester Bivins

FATHER — 13. Birthplace: Salisbury Md

MOTHER — 14. Maiden name: Lillie Prentice

MOTHER — 15. Birthplace: Snowhill Md

16. Informant: Mrs. Lillie Bivins

Address: Salisbury Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan 7th 1945 (month) (day) (year)

Cemetery or crematory: [illegible] Houston

Location: [illegible] Salisbury Md

18. Funeral director: Jones & Stewart

Address: Salisbury Md

19. 1/7/45 (Date rec'd by registrar) Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 4 1945 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1944 to Jan 4 1945

and that I last saw h[illegible] alive on Jan 4 1945

Immediate cause of death: Ruptured gall Bladder with generalized peritonitis.

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas. E. Leach M. D. or other

Address: Salisbury Md. Date signed: 1/6/45

VS A15

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

00957

Reg. Dist. No. 330

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred:

524 Washington Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 524 Washington Street

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Ida B. Hackett

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Harry B. Hackett

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 5, 1869

8. AGE: Years	Months	Days	If less than one day
75	2	8	...hrs. ...min.

9. Birthplace Ohio

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Henry France

FATHER 13. Birthplace Ohio

MOTHER 14. Maiden name Henrietta —

MOTHER 15. Birthplace Ohio

18. Informant Mrs. Louella H. Frase

Address Salisbury, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 16 1945 (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Fredericksburg, Maryland

18. Funeral director J. J. Frampton and Son

Address Fredericksburg, Maryland

19. January 16 1945 (Date rec'd by registrar) J. J. Frampton & Son Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1945, at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1943 1943, to Jan 13 1945 and that I last saw h... alive on Jan 12 1945

Immediate cause of death	DURATION
Bronchopneumonia	3 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE J. Brumm M.D.

M. D. or other

Address Salisbury Date signed June 5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Imley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

00958

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County ..... Salisbury

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred: 520 S. Div. St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 520 S. Division st. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel J. Harrington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida M. Harrington

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 4-1874

8. AGE: Years: 70 Months: 6 Days: 12 If less than one day: ..... hrs. ..... min.

9. Birthplace: Berlin Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Beauchamp Harrington

FATHER — 13. Birthplace: Berlin Md.

MOTHER — 14. Maiden name: Celia Cann

MOTHER — 15. Birthplace: Berlin Md.

16. Informant: Mrs. Ida M. Harrington

Address: 520 S. Div. St. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan. 19-45 (month) (day) (year)

Cemetery or crematory: Berlin M. Cem.

Location: Berlin Maryland

18. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Md.

19. 1/19 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16th 1945 at 5 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Jan 16 1945 and that I last saw h. alive on Jan 16, 1945

Immediate cause of death	DURATION
Cardio vascular renal disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hugo A. Imley M. D. or other

Address Date signed 1/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

00959

CERTIFICATE OF DEATH

Reg. Diat. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 years
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ocean City Blvd. R.D. V
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles E. Keene

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie E. Keene
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): March 20, 1877.

8. AGE:

Years	Months	Days	If less than one day
77	9	28	hrs. min.

9. Birthplace: Whitesville, Sussex, Del. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: ✓

FATHER
12. Name: Clement Keene
13. Birthplace: Sussex Co. Del.

MOTHER
14. Maiden name: Rose Keene
15. Birthplace: Sussex Co. Del.

16. Informant: Edwin F. Keene
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20/45 (month) (day) (year)
Cemetery or crematory: Parsonsburg Church
Location: Parsonsburg, Md.
18. Funeral director: Ide Hill & Wilson Co.
Address: Salisbury, Md.

19. 1/20, 1945 (Date rec'd by registrar) Isaac E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 18, 1945, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1944 to Jan 18 1945 and that I last saw h.. alive on Jan 18 1945

Immediate cause of death	DURATION
(a) Coronary Thrombosis	
Due to	
Due to	
Other conditions: Hypertension, Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertension, Senility
Date of op. Dec 23 1944

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Wm. Hurst M. D. or other
Address: Salisbury Date signed 1-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

06960

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: 310 Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 310 Delaware St

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Catherine Holbrook

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	A-A	Widow

6.(b) Name of husband or wife: John Holbrook

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1885

8. AGE: Years: 59 about | Months: | Days: | If less than one day: hrs. min.

8. Birthplace: Sussex Del (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Domestic

FATHER — 12. Name: Elijah Gannon

FATHER — 13. Birthplace: Del.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Mrs Estell Taylor

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 14. 1945 (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury Md

18. Funeral director: Jessie M Stewart

Address: Salisbury Md

19. 1/14 1945 Harriet L. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 9 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to Jan-9 1945

and that I last saw her alive on ... 19...

Immediate cause of death	DURATION
Cerebral Hemorrhage	Unknown
Due to	
Due to	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Hines R Mann M. D. or other

Address: Salisbury Md Date signed: 1/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0961

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 10 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war: Don't know

3.(a) FULL NAME Dale Hudson

3.(b) Social Security Number Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Don't know

B.(b) Name of husband or wife: Don't know

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1896

8. AGE: Years	Months	Days	If less than one day
about 58	—	—	..... hrs. ..... min.

9. Birthplace: N. C. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Peninsula General Hospital

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18, 1945 (month) (day) (year)

Cemetery or crematory: Public

Location: Salisbury Md.

18. Funeral director: James H. Steward

Address: Salisbury Md

19. 1/18, 1945 (Date rec'd by registrar) Maggie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15, 1945, at 7.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5, 1945 to January 15, 1945, and that I last saw him alive on 1/15/45, 1945

Immediate cause of death	DURATION
Uraemia	several yrs
Due to: Syphilis	2
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. D. Fraker M.D. M. D. or other

Address: Salisbury Md. Date signed: 1/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Emrich.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

06962

CERTIFICATE OF DEATH

Reg. Diat. No. 337

1. PLACE OF DEATH: Wicomico Co

County

City or town: Jyaskin (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Jyaskin (If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #1 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Jarrett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Sallie Fannie Jarrett

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Nov. 1 — 1859

8. AGE:

Years	Months	Days	If less than one day
85	2	27	hr. min.

9. Birthplace: Jyaskin Md. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business:

FATHER — 12. Name: Hazard Jarrett

13. Birthplace: Berlin Md.

MOTHER — 14. Maiden name: Miller

15. Birthplace:

16. Informant: Mrs. William Davis

Address: Jyaskin Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof: Jan 30 1946 (month) (day) (year)

Cemetery or crematory: Parsley Methodist Cemetery

Location: Berlinboro, Md.

18. Funeral director: A. Ira Ed Messick & Sons

Address: Berlinboro Md.

19. Jan 29 1946 (Date rec'd by registrar) R. Wolford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28 1946 at 3.15 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 26 1946

and that I last saw him alive on Jan 28 1946

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William Emrich M. D. or other

Address: Helen - Md. Date signed: Jan 30 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

00963

CERTIFICATE OF DEATH

Reg. Dist. No. 23-3

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 1 hr. 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Salisbury Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Lillian Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Marion E. Jones

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): June 6-1900

8. AGE: Years	Months	Days	If less than one day
44	7	14	...hrs. ...min.

9. Birthplace: Delmar Delaware
(Town, county, and state)

10. Usual occupation: Cashier

11. Industry or business: Dept. Store

FATHER
12. Name: J. Benton Cannon
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Ira Windsor
15. Birthplace: Wicomico Co. Md.

16. Informant: Mr. Marion E. Jones
Address: Salisbury Blvd. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 23-1945 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Maryland

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.

19. 1/23/45 (Date rec'd by registrar) Margaret L. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20, 1945, at 1 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...
Medical examiner certificate

Immediate cause of death	DURATION
Basal fracture of skull	1 hr.
Lacerated Brain	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None ... Date of op. ...

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 1/19/45
Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury: Struck by car. as pedestrian Injured at work? No

23. SIGNATURE: Raymond Lankford M.D. Deputy Medical Examiner
M. D. or other
Address: Salisbury, Md Date signed: 1/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-01)

CERTIFICATE OF DEATH

0C964

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: 111 Cherry St.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 Cherry Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Woolford Killiam

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 21st 1883

8. AGE: Years: 62 | Months | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Salisbury Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Postal Clerk

MOTHER FATHER
12. Name: Jamay C. W. Killiam
13. Birthplace: P.O. Hebron Maryland

MOTHER
14. Maiden name: Elizabeth Margaret Moore
15. Birthplace: Wicomico Co. Maryland

16. Informant: Miss Nellie Killiam
Address: 111 Cherry St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 25-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland

19. (Date rec'd by registrar) 1/26/45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 23rd 1945 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Jan 23 1945 and that I last saw him alive on Jan 22 1945

Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 days

Due to: Hypertension — DURATION: 1942

Due to: Chronic Nephritis

Other conditions: Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Hiram R. Mann M. D. or other
Address: Salisbury Md. Date signed 1/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01019

Reg. Dist. No. 332

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME Arthur Calvin Kuns

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Elizabeth Kuns
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 14 1883

8. AGE: Years	Months	Days	If less than one day
61	4	6	..... hrs. ..... min.

9. Birthplace: Libertown Md
(Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: section R R
12. FATHER Name: Elijah Kuns
13. FATHER Birthplace: Md
14. MOTHER Maiden name: Mary E Kuns
15. MOTHER Birthplace: Md
16. Informant: Charlett Bendell
Address: Pittsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23 1945 (month) (day) (year)
Cemetery or crematory: Parkers Cemetary
Location: n of Pittsville
18. Funeral director: Wm Howard Mills
Address: Pittsville Md
19. 3-19 1945 (Date rec'd by registrar) Lillian T. Davis Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1945, at 12-45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-4-45 1945 to 1-20-45 1945
and that I last saw him alive on 1-20-45 1945

Immediate cause of death	DURATION
Coronary thrombosis	2 wks.
Due to arterio-	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank R Lewis M D
M. D. or other
Address: Willards Md Date signed

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-B)

06965

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 days

Hospital, institution, or street address where death occurred:
P. H. Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Westover Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Kingsbury, Mrs. Thelma.

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife Mr. Paul Kingsbury

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1903

8. AGE: Years	Months	Days	If less than one day
41	2	11	... hrs. ... min.

9. Birthplace St Louis Mo. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name unknown

15. Birthplace

16. Informant Paul Kingsbury

Address Westover Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 9th 1945 (month) (day) (year)

Cemetery or crematory Presbyterian Cem.

Location Princess Anne Md.

18. Funeral director Dale Dashiell

Address Princess Anne Md.

19. 1/7 1945 Received by registrar Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-45 19... at 10:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1 1945, to 1/7 1945

and that I last saw h-er alive on 1/7 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to Intestinal Obstruction	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Intestinal Obstruction

Date of op. 1/1/45

Autopsy results negative

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Chas T. Tilghman M.D.
M. D. or other

Address Salisbury Md Date signed 1/7/45

Evidence for change of year of birth of deceased is shown on 934

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06966

FILM No. G 9 4 MAY 14 1945

Reg. Dist. No. 332

1. PLACE OF DEATH:
County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John James Layton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: ~~Mary~~ Kate Layton
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 16, 1869 — 1868

8. AGE: Years: 76 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER
12. Name: Milburn G. Layton
13. Birthplace: Md.

MOTHER
14. Maiden name: Charlotte ~~Layton~~ Adkins
15. Birthplace: Md.

16. Informant: Edward Layton
Address: Willardsdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-16-45 (month) (day) (year)
Cemetery or crematory: Lewis Cemetery
Location: Willards Md.

18. Funeral director: M. Pasha Watson
Address: Salisbury, Md.

19. 1-16 1945 (Date rec'd by registrar) Lillian R. Davis Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 1945 at 4P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Jan 14 death; and that I last saw him alive on 1-14-45

Immediate cause of death	DURATION
Bronchial Pneumonia	1 wk.
Due to fallowed an auto accident in Dec 1944 Injury was not see	
Due to enough to have anything to do with the final causes of death. Death was due to Chronic myocarditis, Senility; Chronic nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Grant A. Lewis M.D. M. D. or other
Address: Willards Md. Date signed 1-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

00967

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 hours 50 min

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 10 hours 50 min

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke (If outside city or town limits, write RURAL and give nearest town)

Street No.: Fourth Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Anna Littleton

3. (b) Social Security Number ✓

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Gordy Littleton

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): February 18-1862

8. AGE: Years 82 Months 10 Days 21 If less than one day ... hrs. ... min.

9. Birthplace: Hallwood Accomac Va. (Town, county, and state)

10. Usual occupation: house wife

11. Industry or business

FATHER 12. Name: William Groton

13. Birthplace: Virginia

MOTHER 14. Maiden name: Sallie Nock

15. Birthplace: Virginia

16. Informant: Mrs Hattie Young

Address: R.F.D. Pocomoke Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 11-1945 (month) (day) (year)

Cemetery or crematory: Bethany M.P. Cemetery

Location: Pocomoke City Md.

18. Funeral director: Margarette H. Watson

Address: Pocomoke City Md

Feb 5, 1945 Harriet B. [illegible]

19. Jan. 11, 1945 (Date rec'd by registrar) Anne G. Hall Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9, 1945, at 8 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from: Saw patient for death at Pen. Gen. Hospital 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Injured by a fall: fractured hip	11 hours
Due to	
Due to	
Other conditions: C. Arteritis, Anemia (Include pregnancy within 3 months of death)	Years

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 1/8/45

Where did injury occur? Pocomoke (City or town) Worcester (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Fall Injured at work? yes

23. SIGNATURE: N. E. Sartorius M. D. or other

Address: Pocomoke City Md Date signed 1/10/45

Evidence for change of age of deceased is shown on FILM No G 92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00968

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Tyaskin
City or town: Wicomico (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Tyaskin (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Richard B. Long
3. (b) Social Security Number 212-14-4172

4. Sex: male
5. Color or race: col.
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Sarah E Long
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.): Jan 7 1885
8. AGE: Years 60 (59) Months 11 Days 25 If less than one day ... hrs. ... min.
9. Birthplace: Md (Town, county, and state)
10. Usual occupation: General Labor
11. Industry or business
FATHER 12. Name: Dennis Long
13. Birthplace: Rock Creek Md
MOTHER 14. Maiden name: Mary Long
15. Birthplace: Don't Know
16. Informant: Richard Long
Address: Tyaskin Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 7 1945 (month) (day) (year)
Cemetery or crematory: White Haven Md
Location: Back of Al. Gen
18. Funeral director: Mrs. A.G. Wesick Home
Address: Quantico Md
19. Jan 7 1945 (Date rec'd by registrar) K. Woolford Waller, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1945, at 11 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1944, to Jan 1 1945
and that I last saw him alive on Dec 31, 44
Immediate cause of death: Apoplexy
Due to:
Due to: renal arteriosclerosis — DURATION: 2 yr
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: D. Allen Jules M. D. or other
Address: Nanticoke Md Date signed 1-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

00969

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 13 hours 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 East Church Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hattie Barnes Millines

3.(b) Social Security Number 214-10-7485

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Shelley B. Millines

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): August 3, 1908

8. AGE: Years: 36 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Hopkins, Va.
(Town, county, and state)

10. Usual occupation: operator of machine for

11. Industry or business: Manhattan Shirt Co.

FATHER
12. Name: Charles J. Barnes
13. Birthplace: Hopkins, Va.

MOTHER
14. Maiden name: Mamie E. Barnes
15. Birthplace: Hopkins

16. Informant: Shelley B. Millines
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 7, 1946 (month) (day) (year)

Cemetery or crematory: Liberty Cemetery

Location: Parksley, Va.

18. Funeral director: John D. Johnson & Son

Address: Parksley, Va.

19. 1/7 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4, 1945 at 4.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1945, to Jan 4 1945, and that I last saw h alive on 1945

Immediate cause of death	DURATION
Lobar Pneumonia	13 hrs
Due to: Bronchial Pneumonia	4 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W D Lang M.D.
M. D. or other

Address: Princess Anne, Md. Date signed 1/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06979

Reg. Dist. No. 331

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 years
Hospital, institution, or street address where death occurred:
Hebron R. D. 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Spring Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Waller Mills

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm. Dew Mills

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1882

8. AGE: Years: 62 | Months: 3 | Days: 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Quantico Wicomico Co, Md
(Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER
12. Name: Benjamin Waller
13. Birthplace: Wicomico co Md

MOTHER
14. Maiden name: Matilda Venables
15. Birthplace: Wicomico co Md.

16. Informant: Mrs Richard Egerton
Address: Salisbury, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 2/3/46
(month) (day) (year)

Cemetery or crematory: Hebron Cemetary
Location: Hebron Md

18. Funeral director: The Hill & Johnson Co
Address: Salisbury Md

19. Feb 3 1946 Mrs J M Waller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31, 1945, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 27th 1945, to Jan. 31st 1945
and that I last saw ... alive on Jan 31st 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: William Emrick M. D. or other
Address: Helen Md. Date signed: Feb 3-43

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

CERTIFICATE OF DEATH

00971

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 Years
Hospital, Institution, or street address where death occurred:
P. T. Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 906 North Division St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Leila B. Mitchell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Watson D. Mitchell
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Sept 16, 1874

8. AGE: Years: 70 | Months: 4 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Riverdale, Wicomico Co. Md (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:
MOTHER FATHER
12. Name: George D. Insley
13. Birthplace: Wicomico Co. Md
MOTHER
14. Maiden name: Anne P. Hearman
15. Birthplace: Wicomico Co Md
16. Informant: W. D. Mitchell
Address: Salisbury Md
17. Burial (Burial, cremation, or removal) Which? Date thereof 1/29/45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md
18. Funeral director: The Hill & Johnson Co
Address: Salisbury, Md
19. 1/29 1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 26 1945 at 4 10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19.. to Jan 26 1945
and that I last saw h[illegible] alive on Jan 26 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	2 yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jos. Wanner M. D.
M. D. or other
Address: Salisbury Md Date signed 1/25/45

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Daisy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

00972

Reg. Diat. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: P.B. Hoyt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. RD. #3

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Samuel Jerome Moore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara Emma Moore

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): April 13- 1880

8. AGE:

Years	Months	Days	If less than one day
64	9	14	... hrs. ... min.

9. Birthplace: Pittsville Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER

12. Name: Edward James Moore

13. Birthplace: Pittsville Md.

MOTHER

14. Maiden name: Theodosia Bivins

15. Birthplace: Pittsville Md.

16. Informant: Mrs. Clara E. Moore

Address: RD. #3. Salisbury Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Jan. 30-45 (month) (day) (year)

Cemetery or crematory: Parsonsburg Church Cem.

Location: Parsonsburg Md.

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Md.

19. 1-30-1945 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 27th 1945 at 9:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1945, to Jan 27 1945

and that I last saw h... alive on Jan 27 1945

Immediate cause of death: Cardiac Thrombosis — Duration: 24 hrs

Due to: Diabetes Gangrene Foot. — 6 mos

Due to: Senile Nephritis — 7 yrs

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H O Davis M D

M. D. or other

Address: Fruitland Date signed: 1/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

00973

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 115 Ward Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 4 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Delmar Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R F D # 3
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Washington Nichols

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Elizabeth A. Nichols
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6 1857

8. AGE: Years 87 | Months | Days | If less than one day hrs. min.

9. Birthplace Delmar, Maryland (Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business Farm
FATHER 12. Name Isaac W. Nichols
13. Birthplace Wicomico County, Md.
MOTHER 14. Maiden name Amanda Heaps
15. Birthplace Wicomico County Md.
16. Informant John K. Nichols
Address Delmar, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-17-45 (month) (day) (year)
Cemetery or crematory Nichols
Location Delmar, Md
18. Funeral director W. S. Mumford Co
Address Delmar, Delaware
19. Jan. 17, 1945 (Date rec'd by Registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1945, at 11 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to Jan. 14 1945
and that I last saw h alive on Jan 10 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hr.
Due to Chronic Myocarditis	5
Due to Chronic Interstitial Nephritis	5
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. E. Lecates M. D.
Address Delmar Del Date signed 1/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

00974

Reg. Dist. No. 332

1. PLACE OF DEATH:

County: Wicomico

City or town: Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or Institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Parsonsburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION) no

2.(a) If veteran, name war

3.(a) FULL NAME Jennie Parker

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a.a.	Widow

6.(b) Name of husband or wife: Emmett Parker

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1863

8. AGE: Years	Months	Days	If less than one day
81 about	—	—	...hrs. ...min.

9. Birthplace: Pocomoke City Md (Town, county, and state)

10. Usual occupation: Home keeper

11. Industry or business: Same as above

FATHER — 12. Name: Harry Parker

FATHER — 13. Birthplace: Pocomoke City

MOTHER — 14. Maiden name: Annie Shepherd

MOTHER — 15. Birthplace: Pocomoke City Md

18. Informant: Galdie E. Gordy

Address: Parsonsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 10 1945 (month) (day) (year)

Cemetery or crematory: Glenn Hill

Location: Parsonsburg Md

18. Funeral director: James A. Stewart

Address: Salisbury Md

19. Jan 10 1945 (Date rec'd by registrar) Lillian A. Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-2 1945 at 5-P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-29 1944 to 1-2 1945 and that I last saw her alive on 1-2 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Angina Pectoris	2 days
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles F. Brooks M.D. M. D. or other

Address: Salisbury Md Date signed 1-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

00975

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred: Peninsula Gen. Hospital
How long in hospital or institution? 4 days 5 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 Brown st
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Horace Thomas Pennewell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie E. Pennewell
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): May 21 - 1888

8. AGE: Years	Months	Days	If less than one day
56	8	1	hrs. min.

9. Birthplace: R.D. Snow Hill Md
(Town, county and state)
10. Usual occupation: yard Foreman
11. Industry or business: Lumber Mill
FATHER 12. Name: Thomas Pennewell
FATHER 13. Birthplace: Worcester Co. Md.
MOTHER 14. Maiden name: Ida Dennis
MOTHER 15. Birthplace: Worcester Co. Md.
16. Informant: Mrs. Beulah Beatten
Address: 105 Virginia ave. Salisbury Md
17. Buried (Burial, cremation, or removal, Which?) Date thereof: Jan. 25-1945 (month) (day) (year)
Cemetery or crematory: Nazareth Church Cem
Location: Worcester Co. Maryland
18. Funeral director: Hollowa & Walter R. Holloway
Address: Salisbury Maryland.
19. 1/25/45 (Date rec'd by registrar) Horace T. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22 nd 19 45 at 10.15 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 18 1944 to Jan 22 1945 and that I last saw h. alive on Jan 21 1945

Immediate cause of death	DURATION
Coronary Thrombosis	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. Wanner M.D
M. D. or other
Address: Salisbury Date signed: 1/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-0)

CERTIFICATE OF DEATH

06976

Reg. Dist. No. 923

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred: 302 Anne street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 302 Anne street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Georgeanna Perouette

3.(b) Social Security Number

4. Sex	5. Color or race	7.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George H. Perouette
6.(c) If wife, give age: Dead years

7. Birth date of deceased (mo., day, yr.): June 5 1875

8. AGE: Years: 69 | Months: 7 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Wye Mills Md. (Town, county, and state)
10. Usual occupation: Home mf
11. Industry or business: at Home

FATHER
12. Name: Joshua Sperry
13. Birthplace: St. Michaels Md.

MOTHER
14. Maiden name: Sallie Price
15. Birthplace: St. Michaels Md.

16. Informant: Mrs. Earl White
Address: 9. Wood st. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 27-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland

18. Funeral director: Hollowy & Walter R. Hollowy
Address: Salisbury Maryland

19. 1/27/1945 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan ~~July~~ 19 45 at 7 10a M

I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 19 19 45 to Jan 19 19 45
and that I last saw her alive on Jan 15 19 45

Immediate cause of death	DURATION
Cardiac Decomp	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. Gray M. D. or other
Address: Salisbury Md Date signed 1/20/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

00977

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred: 308 Naylor St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 308 Naylor St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Purnell L. Phillips

3.(b) Social Security Number:

4. Sex: Male | Color or race: White | 5.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Jennie Mae Phillips

6.(c) If alive, give age: Dead. years

7. Birth date of deceased (mo., day, yr.): July 4- 1860

8. AGE: Years: 84 | Months: 6 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: R.D. Snow Hill Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER
12. Name: George William Phillips
13. Birthplace: Sussex Co. Del.

MOTHER
14. Maiden name: Mary Anne Fadder
15. Birthplace: Sussex Co. Del.

16. Informant: Mr. James E. Phillips
Address: 421. E. Williams St. Salisbury Md.

17. Buried (Burial, cremation, or removal) Which? Date thereof Jan. 14-45 (month) (day) (year)
Cemetery or crematory: Mt. Ariel Cem.
Location: Wicomico Co. Maryland

18. Funeral director: Holloway & Walter E. Holloway
Address: Salisbury Maryland

19. 1/14/45 (Date rec'd by registrar) 1945 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 11th 1945 at 9 a.m.

I HEREBY CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1945 to Jan 11 1945 and that I last saw h.. alive on Jan 11 1945

Immediate cause of death	DURATION
Bronchial Pneumonia	
Due to: Congestive Heart Failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Rivers Hanson, M.D. M. D. or other
Address: Salisbury, Md. Date signed: 1/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2nd)

06978

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: RD #4.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newboro infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. RD. #4. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clara Nichols Pryor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widow

6.(b) Name of husband or wife: George M. Pryor
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Dec. 27- 1861

8. AGE: Years	Months	Days	If less than one day
83		10	hrs. min.

9. Birthplace: RD. #4. Salisbury Maryland (Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business: at Home

FATHER
12. Name: Isaac Wilbur Dryden
13. Birthplace: RD. #4. Salisbury Maryland

MOTHER
14. Maiden name: Elmira Musick
15. Birthplace: RD. #4. Salisbury Maryland

16. Informant: Mr. Marion S. Pryor
Address: RD. #4. Salisbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury, Maryland.

19. 1/8 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 6th 1945 at 7:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Jan 6 1945 and that I last saw h-er alive on Jan 5 1945

Immediate cause of death	DURATION
Coronary Thrombosis	3 days
Due to: Hypertension	5 yrs.
Due to:	
Other conditions: Valvular Heart Disease	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard R. Yeatman M. D. or other
Address: Salisbury Md. Date signed 1/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00979

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH: Wicomico
County
City or town Hebron
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred: Chestnut Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chestnut street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jackson Llewlyn Reddish

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Flora H. Reddish
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.): April 2 - 1876
8. AGE: Years 68 Months 9 Days 27 If less than one day ....hrs. ....min.
9. Birthplace R.D. Delmar Delaware (Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business
FATHER 12. Name Levin Reddish
FATHER 13. Birthplace R.D. Salisbury Maryland
MOTHER 14. Maiden name Hester Heath
MOTHER 15. Birthplace Near Delmar Delaware
16. Informant Mrs. Flora H. Reddish
Address Chestnut St. Hebron, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31. 1945 (month) (day) (year)
Cemetery or crematory Hastings Cem.
Location Near Delmar Md.
18. Funeral director Holloway & C. Walter K. Holloway
Address Salisbury Maryland.
19. Jan 30 1945 Mrs M. M. Wadey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1945 at 5 a. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1 1945 to January 29 1945 and that I last saw him alive on January 29 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Emrich M. D. or other
Address Hebron - Md. Date signed 1/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-d)

CERTIFICATE OF DEATH

00980

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 4 days - 18½ hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Chesley Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Winfield L. Robertson

3. (b) Social Security Number: 220-12-2022

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Rosa E. Robertson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1865

8. AGE: Years	Months	Days	If less than one day
80	0	6	..... hrs. ..... min.

9. Birthplace: White Haven, Wicomico Md
(Town, county, and state)

10. Usual occupation: Retired Watchman & Farmer

11. Industry or business

FATHER
12. Name: George H. Robertson
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Martha Larmore
15. Birthplace: Wicomico Co. Md

16. Informant: Brooke Robertson
Address: Chester, Va. Rt. 2 Box 234

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/14/45 (month) (day) (year)

Cemetery or crematory: Robertson Cemetery

Location: Clara Md.

18. Funeral director: The Hill & Johnson Co

Address: Salisbury Md.

19. 1/14 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11 1945, at 7 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1945, to Jan 11 1945, and that I last saw him alive on Jan 11 1945

Immediate cause of death	DURATION
Cardiac Decomp.	
Due to: Arteriosclerotic Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jno. D. Gray M. D. or other

Address: Salisbury Date signed: Jan 14, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

00981

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hosp.
How long in hospital or institution? 5 days 10 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Rawley Richard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	

6.(b) Name of husband or wife: Annie L. Rawley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 20, ~~1873~~ 1872

8. AGE: Years: 72 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Stockton, Md.
(Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

FATHER — 12. Name: William Mason
13. Birthplace

MOTHER — 14. Maiden name: Sarah Rawley
15. Birthplace

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/7/46 (month) (day) (year)
Cemetery or crematory: James Hill Cemetery
Location

18. Funeral director: Irvin Bennett
Address: Stockton md

19. 1/7 (Date rec'd by Registrar) 1946 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1945, at 6:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1944, to Jan 6 1945
and that I last saw h[illegible] alive on Jan 6 1945

Immediate cause of death	DURATION
Chr. Nephritis	Yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: V
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Date signed 1/6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00982

Reg. Dist. No. 333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs. 19 minutes

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 4 hrs. 19 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 915 Walnut Street, Pocomoke, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Girl Bandberg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 25, 1945

8. AGE: Years | Months | Days | If less than one day: 4 hrs. 19 min.

9. Birthplace: Wicomico Co, Md (Town, county and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Paul Ludwig Bandberg

FATHER — 13. Birthplace: Berg Mecklenburg

MOTHER — 14. Maiden name: Ruth Louise Hayes

MOTHER — 15. Birthplace: Toledo, Ohio

16. Informant: Paul Ludwig Bandberg

Address: 915 Walnut Street, Pocomoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md.

18. Funeral director: The Hill & Graham Co.

Address: Salisbury, Md.

19. 1/27/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26, 1945 at 3:29 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 25, 1945 to Jan. 26, 1945 and that I last saw her alive on Jan. 26, 1945

Immediate cause of death	DURATION
Premature Birth (6½ mos. pregnancy)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James R. Mann M. D. or other

Address: Delmar, Md. Date signed: 1/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

00983

CERTIFICATE OF DEATH

Reg. Dist. No. 64 330

1. PLACE OF DEATH:

County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Frederick Thomas

3.(b) Social Security Number 214-12-5552

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Edna Thomas

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) May 30, 1880

8. AGE:

Years	Months	Days	If less than one day
64	8	0	...hrs. ...min.

9. Birthplace Wicomico County, Maryland (Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business Farm

FATHER 12. Name Lewis J. Thomas

13. Birthplace Wicomico County, Maryland

MOTHER 14. Maiden name Rhoda C. Hall

15. Birthplace Wicomico County, Maryland

16. Informant Edna Thomas

Address Mardela Springs, Maryland R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 2 1945 (month) (day) (year)

Cemetery or crematory Mardela Colored Cemetery

Location Mardela Springs, Maryland

18. Funeral director J. J. Frampton & Son

Address Federalsburg, Maryland

19. February 2 1945 (Date rec'd by registrar) J. J. Frampton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1945, at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1945, to Jan 30 1945

and that I last saw h... alive on Jan 27 1945

Immediate cause of death	DURATION
(a) Uremia Sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. S. Tuckerman M. D.

Address Sharptown Md Date signed 2/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of year of birth of deceased is shown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

FILM No. G 94 MAY 14 1945

00984

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town White Haven, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town White Haven
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Major Thomas

3. (b) Social Security Number 214-18-4606

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	married

6.(b) Name of husband or wife Nancy Thomas

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1870 1869

8. AGE:

Years	Months	Days	If less than one day
75	9	23	hrs. min.

9. Birthplace Smiths Island, Md.
(Town, county, and state)

10. Usual occupation Corker

11. Industry or business

FATHER 12. Name Philip Thomas

13. Birthplace Crisfield, Md.

MOTHER 14. Maiden name Unknown

15. Birthplace Crisfield

16. Informant Nancy Thomas

Address White Haven, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 4 1945 (month) (day) (year)

Cemetery or crematory Cemetery

Location White Haven, Md.

18. Funeral director Mrs. C. Mason & Sons

Address Pisalve Md

19. Feb 4 1945 (Date rec'd by registrar) R. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29th 1945 at 10.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1944 to Jan 29 1945 and that I last saw h.. alive on Jan 29 - 1945

Immediate cause of death	DURATION
Pulmonary,	
Due to Tuberculosis	6 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L Allen Tull M. D. or other

Address Marion Md Date signed 2-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

Dr. Daisy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

06985

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: R.D. #2. Spring Hill Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #2 Spring Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Calvin Trader

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Matilda Smith Trader
If (c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Dec. 13th 1871

8. AGE: Years: 73 | Months: 1 | Days: 2 | If less than one day: ... hrs. ... min.

9. Birthplace: Salisbury Md. (Town, county, and state)
10. Usual occupation: Retired Clerk
11. Industry or business: Railway Express Agency

FATHER
12. Name: Hobart Trader
13. Birthplace: Salisbury Md.

MOTHER
14. Maiden name: Clara Fooks
15. Birthplace: Salisbury Md.

16. Informant: Mrs. Matilda S. Trader
Address: R.D. #2. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 18-45 (month) (day) (year)
Cemetery or crematory: Parsons Fun.
Location: Salisbury Maryland

18. Funeral director: Holloway & Co. Walter P. Holloway
Address: Salisbury Maryland

19. 1/18 1945 Edna E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15th 1945 at 10.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1945, to Jan. 15 1945 and that I last saw him alive on Jan. 15 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days
Due to Hypertension	6 mos
Due to Arteriosclerosis	2 yrs
Other conditions C.R. Dis. Nephritis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H.D. Sandy M.D.
M. D. or other
Address: Date signed: 1/16/45

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

06985 Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 8 years
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Mary H. Pull

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W.a.	widow

6.(b) Name of husband or wife: Wm. Pull
6.(c) If alive, give age: Don't know years
7. Birth date of deceased (mo., day, yr.): —

8. AGE: Years: about 71 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: Trinton N.J. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Same as above
12. FATHER — Name: Washington H. Rudell
13. FATHER — Birthplace: Bridgeton Subject
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace: Unknown
16. Informant: Mrs. Edmund Cook
Address: Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24 - 1945 (month) (day) (year)
Cemetery or crematory: Odd Fellows
Location: Webster Mem. Md
18. Funeral director: James H. Stewart
Address: Salisbury Md
19. 1/25 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 January 1945, at 39 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3 1945, to Jan. 22 1945
and that I last saw h.e.r. alive on January 22 1945

Immediate cause of death	DURATION
Cerebral coma	
Due to: Chronic Nephritis - Arteriosclerosis	
Due to: Arterio Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arthur L. Browne M.D. M. D. or other
Address: Salisbury - Md Date signed: 1/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(Dr. Wannue) MARYLAND STATE DEPARTMENT OF HEALTH 11:987

2411 N. Charles St., Baltimore (83-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 335

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Nicomis

County Salisbury

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred: P. H. Hoyt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Nicomis

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 1210 E. Church st. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Kirk Turner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Maggie S. Turner

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) No Record.

8. AGE: Years 80 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace Tyaskin Md. (Town, county, and state)

10. Usual occupation retired

11. Industry or business Farmer

FATHER 12. Name James Turner

FATHER 13. Birthplace Tyaskin Md.

MOTHER 14. Maiden name Tyaskin

MOTHER 15. Birthplace Tyaskin Md.

16. Informant Mrs. Maggie S. Turner

Address 1210 E. Church St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31-45 (month) (day) (year)

Cemetery or crematory Tyaskin Church Cem

Location Tyaskin Md.

18. Funeral director Hollaway & Co. Walter R. Holloway

Address Salisbury Maryland

19. 1/31/46 (Date rec'd by registrar) Maggie S. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28th 1945 at 950p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 22 1945, to Jan 28 1945 and that I last saw h[illegible] alive on June 28 1945

Immediate cause of death R. Cresmphlegia — DURATION 4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Wannue M. D. M. D. or other

Address Salisbury Date signed 1/29/46

Dr. ~~Dixey~~ Turley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

00988

Reg. Dist. No. 333

1. PLACE OF DEATH

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution or street address where death occurred: P. B. Hoyt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico Co

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 301 E. Vine St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah Emma Tinley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Amelius P. Tinley

6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) June 5 - 1870

8. AGE: Years 74 Months 7 Days 10 If less than one day ... hrs. ... min.

9. Birthplace R.D. #4 Salisbury Md. (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business at Home

FATHER 12. Name John Riddick

FATHER 13. Birthplace R.D. #4 Salisbury Md.

MOTHER 14. Maiden name Sallie Ann Staton

MOTHER 15. Birthplace R.D. #4 Salisbury Md.

16. Informant Amelius P. Tinley

Address 301 E. Vine St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 20-45 (month) (day) (year)

Cemetery or crematory Wi Co. Memorial Park

Location Salisbury Md

18. Funeral director Holloway & Co. Walter R. Holloway

Address Salisbury Md.

19. 1/20/45 (Date rec'd by registrar) Beatrice E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1945 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1945 to Jan 15 1945

and that I last saw h alive on Jan. 15 1945

Immediate cause of death	DURATION
Strangulated Hernia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clarence E. Tinley M. D. or other

Address Salisbury Md. Date signed 1/16/45

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00989

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Isaac Levine Waller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Millie Anne Waller
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Sept. 3 1860

8. AGE: Years	Months	Days	If less than one day
84	3	11	hrs. min.

9. Birthplace: Mardela Wicomico Co. Md.
(Town, county, and state)
10. Usual occupation: Farming
11. Industry or business
FATHER — 12. Name: Stanley Waller
13. Birthplace: Mardela Md.
MOTHER — 14. Maiden name: Unknown
15. Birthplace
16. Informant: Millie Anne Waller
Address: Salisbury, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/26/45 (month) (day) (year)
Cemetery or crematory: Mardela Cem.
Location: Mardela Md.
18. Funeral director: Wm. C. Messick Sons
Address: Delmar Md.
19. 1/26 19 45 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/23/45 19 at 11:05 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/ 19 45, to 1/23 19 45
and that I last saw him alive on 1/21 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	Last attack 2 hours
Due to: Hypertension	
Due to:	
Other conditions: Valvular Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hunter R. Mann M. D. or other
Address: Salisbury Md. Date signed 1/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (748)

00990

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County ..... Salisbury
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ..... Lifetime
Hospital, institution, or street address where death occurred: P.B. Hoyt
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State ..... Md. County ..... Wicomico
City or town ..... Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. ..... R.D. #3 Jasmine Road
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Mayhew Wheatland
3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Nora C. Wheatland
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): Oct. 7 - 1889

8. AGE: Years: 55 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Wico. Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Marion Wheatland
13. Birthplace: Allen Md.
MOTHER 14. Maiden name: Williamanna Brinkley
15. Birthplace: Silvam Md.
16. Informant: Mrs. Nora C. Wheatland
Address: R.D. #3 Salisbury Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 24 45 (month) (day) (year)
Cemetery or crematory: Parsons Mem.
Location: Salisbury Md.
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.
19. 1/24/46 (Date rec'd by registrar) Carroll E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 20 45 at 10 15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6 45, to Jan 20 45
and that I last saw him alive on Jan 20, 45
Immediate cause of death: Cerebral Embolism — DURATION
Due to: Arteriosclerosis
Due to: .....
Other conditions: .....
(Include pregnancy within 3 months of death)
Major findings of operations: No Operation
Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?
23. SIGNATURE: D. Allen Fields, M.D. M. D. or other
Address ..... Date signed 1/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

00991

CERTIFICATE OF DEATH

Reg. Dist. No. 3321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town near Pittsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Pittsville (rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ernest Belle White.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Sallie M. White.

Pittsville Md. 6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Dec 15 - 1867

8. AGE:

Years	Months	Days	If less than one day
77	0	17	...hrs. ...min.

8. Birthplace Pittsville, Md.
(Town, county, and state)

10. Usual occupation merchant.

11. Industry or business

FATHER
12. Name John W. White.
13. Birthplace Pittsville Md.

MOTHER
14. Maiden name Laura Freeny.
15. Birthplace Pittsville Md.

16. Informant Mrs. Sallie M. White.

Address Pittsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4th 1945 (month) (day) (year)

Cemetery or crematory Friendship.

Location near Pittsville, Md.

18. Funeral director Wm. Howard Wells.

Address Pittsville, Md.

19. Jan. 4 1945 (Date rec'd by registrar) Lillian R. Davis Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2nd 1945, at 7:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1940 19... to date of death 19...

and that I last saw him alive on Dec. 30, 1944 19...

Immediate cause of death	DURATION
Chronic Int. nephritis,	
Chronic myocarditis	8 yrs.
Due to (b) Hypertension.	
Due to	
Other conditions Central hemorrhage 5 yrs ago.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank P. Lewis M.D. M. D. or other

Address Pittsville Md. Date signed 1-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-D

00992

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 years
Hospital, Institution, or street address where death occurred: 106 Parson St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 106 Parson St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Lillie P. Windsor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: E. W. Windsor
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): April 29, 1865

8. AGE: Years	Months	Days	If less than one day
79	8	8	hrs. min.

9. Birthplace: Salisbury, Wicomico Co. Md.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:

FATHER
12. Name: Samuel Disharoon
13. Birthplace: Wicomico Co. Md

MOTHER
14. Maiden name: Mary Williams
15. Birthplace: Wicomico Co. Md

16. Informant: E. W. Windsor
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/9/1945 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md.

19. 1/9 (Date rec'd by registrar) 1945 Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7, 1945, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1945, to Jan 8 1945, and that I last saw h[illegible] alive on Jan 7 1945

Immediate cause of death	DURATION
Heart Failure (RT)	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: [illegible] Date signed: 1/9/1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15